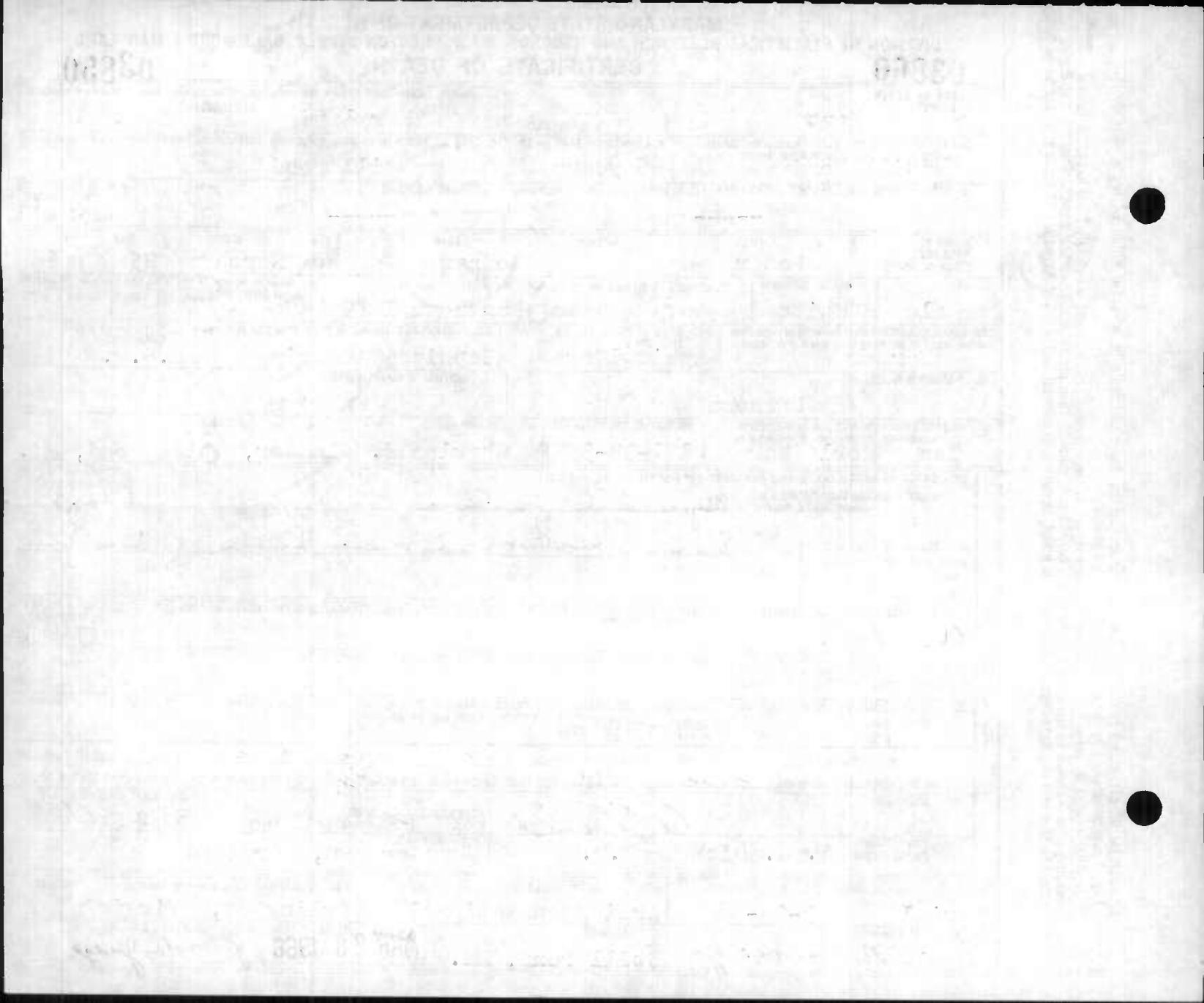


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																											
CERTIFICATE OF DEATH																											
1. PLACE OF DEATH a. COUNTY Kent				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Kent																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond				c. LENGTH OF STAY IN 1b 5 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Still Pond																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)								d. STREET ADDRESS																			
3. NAME OF DECEASED (Type or print) Peter				First	Middle	Last	4. DATE OF DEATH March 25 1966	Month	Day	Year																	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input checked="" type="checkbox"/>	OIVORCED <input type="checkbox"/>	8. OATE OF BIRTH unknown 1889	9. AGE (in years last birthday) 77 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HOURS	MIN.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Agriculture				11. BIRTHPLACE (County & State, or foreign country) Zepnic Austria				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War I								16. SOCIAL SECURITY NO. 101-32-3978				17. INFORMANT Charles J. Glasser, Still Pond, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure												INTERVAL BETWEEN ONSET AND DEATH 2 days															
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 4221												DUE TO (b) Generalized arteriosclerotic cardio vascular disease															
DUE TO (c)												Lung gears															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) All shucks												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While at work								20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory				20f. (City or town) (County) (State) Chestertown, Maryland			
21. I certify that (I) (this hospital) attended the deceased from 3-8 1966 , to 3-20 1966 , that (I) (we) last saw the deceased alive on 3-20 1966 , and that death occurred at 6 AM , from the causes and on the date stated above.												22a. SIGNATURE A.C. Dick												22b. DATE SIGNED 3-25-66			
22c. PHYSICIAN'S NAME (Type) A. C. Dick M.D.				22d. ADDRESS Chestertown, Maryland				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial								23b. DATE THEREOF 3-29-66				23c. NAME OF CEMETERY OR CREMATORIAL Arlington National				23d. LOCATION (City, town or county) (State) Arlington, Virginia			
24. FUNERAL DIRECTOR Victor N. Kennedy								ADDRESS Still Pond, Md.				25a. REC'D. BY REGISTRAR MAR 28 1966				25b. REGISTRAR'S SIGNATURE Charles Judge											



1
FOR STATE
HEALTH DEPT.

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Rural c. LENGTH OF STAY IN 1b lifetime				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown Rural 14-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home Flatland Road				d. STREET ADDRESS Flatland Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First John Martin Curlett Middle			Last			4. DATE OF DEATH Mar. 10, 1966			Month 19 Day Year		
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12/23/1922		9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor				10b. KIND OF BUSINESS OR INDUSTRY owner				11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.			
								12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Curlett				14. MOTHER'S MAIDEN NAME Martha Williams							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service) yes WW 11		16. SOCIAL SECURITY NO. 219 12 9991		17. INFORMANT Diana H. Curlett RFD		Address Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease INTERVAL BETWEEN ONSET AND DEATH short											
421 DUE TO Deceased had complained of chest pain off and Conditions, If any, which gave rise to immediate (b) on for a period of two or three weeks. He was cause (a), stating the (c) found dead in his work-shop by his son.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Robert W. Farr				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 3/10/66			
EXAMINER'S NAME (Type) Robert W. Farr				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Kent County Chestertown, Md. Address (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/12/66		23c. NAME OF CEMETERY OR CREMATORIUM I. U. Cemetery		23d. LOCATION (City, town or county) Rural		(State) Worton, Md.			
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR MAR 14 1966		25b. REGISTRAR'S SIGNATURE jCharles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03862

CERTIFICATE OF DEATH

03852

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	c. LENGTH OF STAY IN lb 16 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	d. STREET ADDRESS 202 Mt. Vernon Avenue
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Lealand Cushing	First Raymond	Middle Lealand	Last Cushing
4. DATE OF DEATH March 25 1966	Month March	Day 25	Year 1966
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-02
9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY Campbell Soup Co.	11. BIRTHPLACE (County & State, or foreign country) Canada	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Robie Cushing	14. MOTHER'S MAIDEN NAME Addie Kempton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	16. SOCIAL SECURITY NO. 413-03-4757	17. INFORMANT Hospital Records	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation INTERVAL BETWEEN ONSET AND DEATH 20 minutes			
4201 DUE TO Myocardial Infarction 26 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Coronary atherosclerosis several yrs			
stating the underlying cause (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-9 1966 , to 3-25 1966 , that (I) (we) last saw the deceased alive on 3-25 1966 , and that death occurred at 2 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Robert W. Farr</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/27/66
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/66	23c. NAME OF CEMETERY OR CREMATORIALy Chester Cemetery	23d. LOCATION (City or Town) (County) (State) Chestertown, Md.
24. FUNERAL DIRECTOR Marvin V. Williams		ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR MAR 29 1966
			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

52260

52260

100

100

100

100

100

100

100

100

0

0

0

100

100

100

0

100-8

0

0

100

100

100

100

100

100

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03863

CERTIFICATE OF DEATH

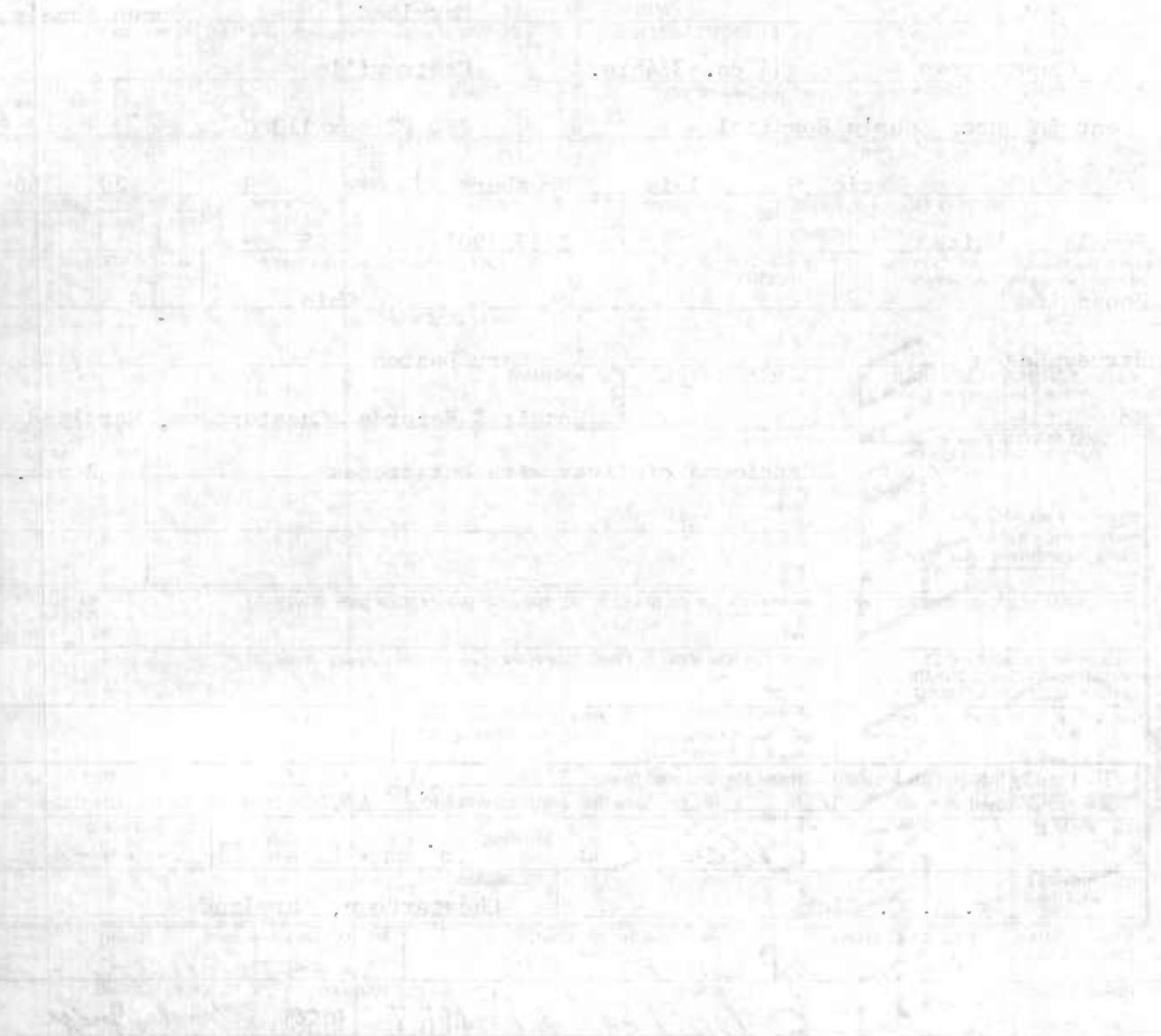
113853

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE Maryland Queen Anne's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 5 da. 63/4 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17-2						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital			d. STREET ADDRESS RFD #2 Box 113 C							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First Marie	Middle Elsie	4. DATE OF DEATH 3	Month 29	Day 19	Year 66			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/17/1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Ohio			12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Harvey Sego			14. MOTHER'S MAIDEN NAME Mary Beaton			Address				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.			17. INFORMANT			Hospital Records Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver with Metastases INTERVAL BETWEEN ONSET AND DEATH 1561 2 yrs. DUE TO Conditions, if any, which gave rise to immediate cause (a). (b) _____ stating the underlying cause last. (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. P.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/24 1966, to 3/29 1966, that (I) (we) last saw the deceased alive on 3/29 1966, and that death occurred at 10 A.M., from causes and on the date stated above.										22b. DATE SIGNED 3-29-66
22a. SIGNATURE A. C. Dick			22b. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL MAR. 31-66		23b. DATE THEREOF Ch ESTER		23c. NAME OF CEMETERY OR CREMATORIAL ESTER		23d. LOCATION (City or Town) (County) (State) Chestertown Kent, Md				
24. FUNERAL DIRECTOR Edgar L Line, Church Hill Md		ADDRESS		25a. REC'D BY REGISTRAR APR 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				
VR A15 (4) 20 M 1/66										

66281

RECEIVED
FEB 16 1969

66281



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

PAGE 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03864

03854

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent County, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown and Short		b. COUNTY Kent County	
c. LENGTH OF STAY IN 1b DR. FARR OFFICE 1924 High St Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 14-1		d. STREET ADDRESS 14-1	
3. NAME OF DECEASED (Type or print)	First Aretha	Middle Stephania	Last Hicks
4. DATE OF DEATH Month 3	Day 7	Year 1966	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1965
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Alfred Hicks	14. MOTHER'S MAIDEN NAME Hilda Wickes	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Alfred Hicks Rock Hall, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 40 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 66 to 3-7 , 19 66 that (I) (we) last saw the deceased alive on 3-7 19 66 and that death occurred 3-8-66 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Farr			
22c. PHYSICIAN'S NAME (Type) Robert W. Farr M.D.		22d. ADDRESS Chestertown, Maryland	22b. DATE SIGNED 3-8-66
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/9/1966	23c. NAME OF CEMETERY OR CREMATORIUM Sharptown Cemetery	23d. LOCATION (City, town or county) (State) Rock Hall, Maryland
24. FUNERAL DIRECTOR Kenneth Wally	ADDRESS Chestertown, Md.	25a. REC'D BY REGISTRAR MAR 11 1966	25b. REGISTRAR'S SIGNATURE J. Charles Judge
5-133555			

Trade am not goin' to
be able to get you

John T.

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03865 03855

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Millington		d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Gilbert	Middle	Last Johnson	4. DATE OF DEATH March 23 1966	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1898	9. AGE (in years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Minutes
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Thomas Johnson		14. MOTHER'S MAIDEN NAME Margaret Boweser		Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Army. W.W.I 217-14-8915		17. INFORMANT Mrs. Alberts Johnson Millington, Maryland		INTERVAL BETWEEN ONSET AND DEATH 3 day			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 231X Bronchopneumonia		DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage		DUE TO (c) Tumor of the lung -		4 days? 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 22 1966 , to March 23 1966 , that (I) (we) last saw the deceased alive on March 22 1966 , and that death occurred at 3 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Genia Koralewski		22b. DATE SIGNED 3.25.66		M.D. ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) Genia Koralewski M.D.		22d. ADDRESS Millington, Maryland 21651							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 26, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Chesterville Cemetery		23d. LOCATION (City, town or county) (State) Millington, Rural Md.			
24. FUNERAL DIRECTOR Edward Fellows		ADDRESS Millington, Maryland		25a. REC'D BY REGISTRAR MR 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then press **PRINT** in any event, within 72 hours after death. It should be filed with the State Dept. of Health prior to burial, cremation, or removal.

100

banivari

100

notability factor

notability factor

88 88 100

notable

notable

88 88 100

x

other than

baseline

noteworthy

notable

notable person

notable person

analysis notability score: 100-100 = 100-100 = 100 - 100 = 100

100 baseline notability

100 notability score

100 notability score difference: 100-100 = 100

baseline notability

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

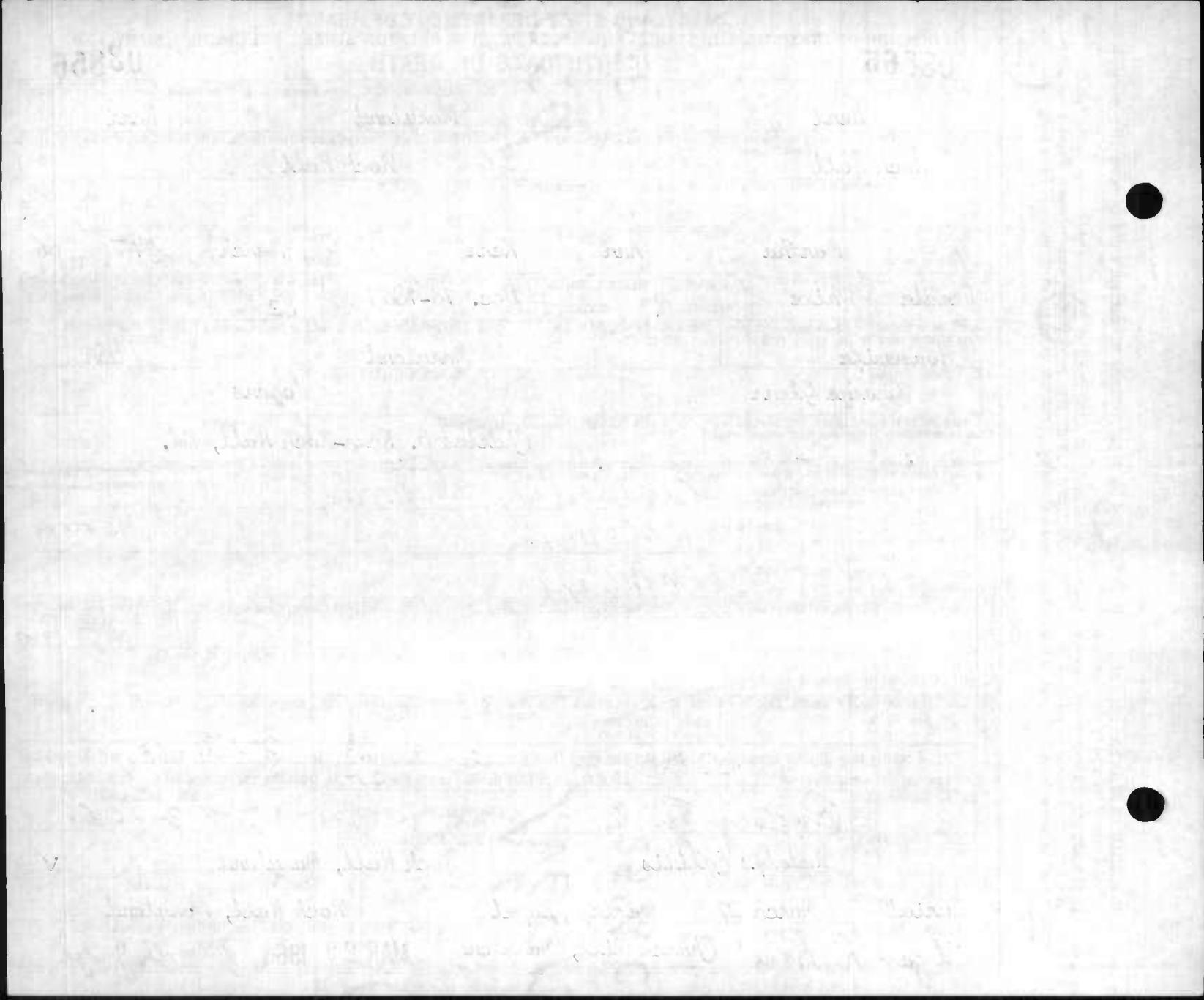
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~use~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and an event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rock Hall		c. LENGTH OF STAY IN 1b		a. STATE Maryland b. COUNTY Kent		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				
14-1								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Year	
Female		Martha	Ann	Kerr	March	24	Day 1966	
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days Hours Min.	
Female		White			Dec. 18-1883	82 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		
13. FATHER'S NAME		George Glenn		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16. SOCIAL SECURITY NO.		Address		
				17. INFORMANT		Charles B. Kerr-Rock Hall, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiovascular insufficiency						
4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	Arteriosclerosis.					
		DUE TO (c)	Old age					
3 weeks								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that (I) (this hospital) attended the deceased from 4-2, 1963, to 3-24, 1966, that (I) (we) last saw the deceased alive on 3-24-1966, and that death occurred at 2 PM, from the causes and on the date stated above.								
22a. SIGNATURE		Rudolph Eglitis						
22c. PHYSICIAN'S NAME (Type)		Rudolph Eglitis						
22d. ADDRESS		Rock Hall, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		23d. LOCATION (City, town or county) (State)		
Burial		March 27		Wesley Chapel		Rock Hall, Maryland		
24. FUNERAL DIRECTOR		Edgar S. Lane Church Hill, Maryland						
		ADDRESS						
		25a. REC'D BY REGISTRAR MAR 29 1966						
		25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M

03867

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03857

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Kent				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		d. STREET ADDRESS 14-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Marie McLain		First Marie	Middle NMN	Last McLain	4. DATE OF DEATH March 20 1966	Month March	Day 20	Year 1966
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-11	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 54	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Durham, North Carolina			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hart (D)				14. MOTHER'S MAIDEN NAME Annie				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 241-36-7796	17. INFORMANT Hospital Records	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Urinary - due to renal failure 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema DUE TO (c) Myocardial decompensation								INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Diabetes mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Chestertown	(County) Maryland	(State) MD	
21. I certify that (I) (this hospital) attended the deceased from 3-17 , 19 66 , to 3-20- , 19 66 , that (I) (we) last saw the deceased alive on 3-20 19 66 , and that death occurred at 3:45 AM , from causes and on the date stated above.								
22a. SIGNATURE Harry P. Ross				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3-21-66	
22c. PHYSICIAN'S NAME (Type) Dr. Harry P. Ross				22d. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/23/1966	23c. NAME OF CEMETERY OR CREMATORIUM JANE'S CEMETERY	23d. LOCATION (City or Town) Chestertown, Maryland		(County) Maryland	(State) MD	
24. FUNERAL DIRECTOR Kenneth Wally				ADDRESS Chestertown, md	25a. REC'D BY REGISTRAR MAR 24 1966	25b. REGISTRAR'S SIGNATURE Charles Judge		

卷之三

270 A

Digitized by srujanika@gmail.com

三

Definitions

10023273003

Journal of World History

- 3 -

P. J. HAN

1. *What is the best way to get rid of a bad habit?*

51-52

[View Details](#)

1953) (and also 1953) (and also 1953)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03858

M

03868

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington (rural)		c. LENGTH OF STAY IN 1b many years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Mattie		First	Middle	Last	4. DATE OF DEATH Month March Day 10 Year 19 66
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1889	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Hopkins, N.C.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Thomas Pilkinton		14. MOTHER'S MAIDEN NAME Kissie C. Eller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 246-28-2344	17. INFORMANT Mrs. Helen M. Rash,	Address Millington, Md. 21651	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable arteriosclerotic Cardiovascular disease INTERVAL BETWEEN ONSET AND DEATH Unknown					
4221 DUE TO Said to have been ill in bed for several days and was found Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) dead in her home, where she lived alone, at about 8:30 to					
DUE TO 9:00 PM, 3/10/66 (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Robert W. Farr</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED March 10, 1966		
EXAMINER'S NAME (Type) Robert W. Farr	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 15, 1966	22c. NAME OF CEMETERY OR CREMATORIUM Millington Cemetery	22d. LOCATION (City, town, or county) Millington, Kent Co., Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Pilkinton Millington, Md.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE Mar 15 1966	24b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL EXAMINER CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
---	---	---	---	---	---	---	---	---	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	-----	------

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03859

1 M 03869		CERTIFICATE OF DEATH						24. FUNERAL DIRECTOR <i>J. Willis Wells</i>		
1. PLACE OF DEATH a. COUNTY Kent			MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey			b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown			c. LENGTH OF STAY IN 1b 4 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasantville			d. STREET ADDRESS 24 E. Frambes Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital									e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Kenneth	Middle George	Last Reese	4. DATE OF DEATH March 16 1966		Month	Doy	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-10-27		9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Engineer			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Dingy Reese (L)										14. MOTHER'S MAIDEN NAME Mildred Theo Sykes (L)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1946		17. INFORMANT Hospital Records		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction										INTERVAL BETWEEN ONSET AND DEATH 4
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Pulmonary edema + congestive failure stating the underlying cause (c) Terminal asystole -										2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. = 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-12- , 19 66 , to 3-16- , 19 66 , that (I) (we) last saw the deceased alive on 3-16 19 66 , and that death occurred at 10:35 M, from causes and on the date stated above.										
22a. SIGNATURE <i>R. W. Farr</i>										22b. DATE SIGNED 3-16-66
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr			22d. ADDRESS Chestertown, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/19/66		23c. NAME OF CEMETERY OR CREMATORIAL Magnolia Cem.			23d. LOCATION (City or Town) (County) (State) Phila. - Co. Penna.			
24. FUNERAL DIRECTOR		ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR MAR 18 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1625

62

travel well

good

Illinoian?

thin

intercations

normal bedrock, A.M.

isolated dark pebbles & shell

rotten

green

green

yellow

E

CS-01-C

other

green

5" thickness

yellowish-green

(1) sand & pebbles

(1) sand & pebbles

greenish-yellow CS-01-C-VI

greenish-yellow

A

CS-01-C

CS-01-C

3

CS-01-C

thin greenish-yellow

thin greenish-yellow

330 ft. below

1 M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03860

1. PLACE OF DEATH
a. COUNTY

Kent County, Maryland MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

R.F.D. Worton, Maryland Lifetime

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

At Home

3. NAME OF DECEASED
(Type or print)First
Amelia

Middle

Last
Robert

4. DATE OF DEATH

Month
3 Day
9 Year
1966

5. SEX

Female

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIOOWEO DIVORCED

8. DATE OF BIRTH

6/17/1888

9. AGE (In years last birthday)

77 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Kent County, Maryland

U.S.A.

13. FATHER'S NAME

Edward Jackson

14. MOTHER'S MAIDEN NAME

Charlotte Snowden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs. Mildred Jeff Worton, Maryland Address R.F.D. #1

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

331X

Cerebro-vascular accident

INTERVAL BETWEEN ONSET AND DEATH

6 weeks

Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.

OUE TO

(b)

Arteriosclerosis, hypertension

OUE TO

(c)

old age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO 20a. ACCIDENT WAS UNDERRYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7-10, 1963, to 2-25-, 1966, that (I) (we) last saw the deceased alive on 2-28-1966, and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE

Rudolfs Eglitis

M.D. ATTENDING PHYS.

ME.O. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

3-10-66

22c. PHYSICIAN'S NAME (Type)

Rudolfs Eglitis M.D.

22d. ADDRESS

Rock Hall, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3/14/1966

23c. NAME OF CEMETERY OR CREMATORIUM

Union Cemetery

23d. LOCATION (City, town or county) (State)

R.F.D. Worton, Maryland

24. FUNERAL DIRECTOR

Kenneth Waley

ADDRESS

Chestertown, Md.

25a. REC'D BY REGISTRAR

MAR 14 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 **M** 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be rejoined by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and never, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

CERTIFICATE OF DEATH

03871 03861

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 17 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall 14-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital, Inc.			d. STREET ADDRESS Rock Hall Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print)	First Howard	Middle William	Last Stewart	4. DATE OF DEATH March 24 1966	Month Doy Year	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12-11-1895	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Alfred Stewart (D)			14. MOTHER'S MAIDEN NAME Melissa Bearyman (D)			Address
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 180-07-1253		17. INFORMANT Hospital Records			18. MEDICAL CERTIFICATION
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 3 months Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO Arteriosclerotic Cardiovascular Disease UNKNOWN stating the underlying cause last. (c) DUE TO Arteriosclerotic Cardiovascular Disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? X YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.	19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-7- , 1966, to 3-24 , 1966, that (I) (we) last saw the deceased alive on 3-24 1966, and that death occurred at 12 45 PM , from causes and on the date stated above.						22b. DATE SIGNED 3/25/66
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Dr. Robert W. Farr		22d. ADDRESS Chestertown, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/28/66	23c. NAME OF CEMETERY OR CREMATORIAL Share Town Cem.	23d. LOCATION (City or Town) Rock Hall	(County) Kent	(State) Md	
24. FUNERAL DIRECTOR Kenneth Waller	ADDRESS Chestertown, Md		25a. REC'D. BY REGISTRAR MAR 29 1966	25b. REGISTRAR'S SIGNATURE 		
VR A15 (4) 20 M 1/66						

Journal of Health Politics

Litho-boat

卷之三

• 201 (202) of 201 • [Search page](#) | [Index](#)

卷之三

THE PRACTICAL

Digitized by srujanika@gmail.com

• A. S. 1937 •

Digitized by srujanika@gmail.com

706

10. *Chlorophytum comosum* (L.) Willd.

www.ijerph.org | ISSN: 1660-4601 | DOI: 10.3390/ijerph1009094

81

2

100

Answers

Final Report pg 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Kent MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 25 days						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown 14 1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Arthur	Middle Thomas	Last Stryckning	4. DATE OF DEATH 3 29 1966			Month	Day	Year
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/86			9. AGE (in years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Thomas Stryckning						14. MOTHER'S MAIDEN NAME Rebecca					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 218-20-6686			17. INFORMANT Hospital Records			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-Vascular Disease</i> / 10 yrs. 4221 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) <i>OK. I know about this case - Dr. Keefe had little to do with death</i> <i>Arthur T. Keefe, M.D., Dpt. Med Ex - Chestertown</i> (c) <i>Fracture of Left H. o</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part i or Part II of item 18.) <i>Fell at home</i>											
20c. TIME OF INJURY Hour a.m. 3. 4 p.m. 1966			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) (County) (State) Kent Md		
21. I certify that (I) (this hospital) attended the deceased from 3. 4, 1966 to 3. 29, 1966 that (I) (we) last saw the deceased alive on 3. 29, 1966, and that death occurred at 62 M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Arthur T. Keefe, M.D.</i>						22b. DATE SIGNED 3/31/66					
22c. PHYSICIAN'S NAME (Type) Arthur T. Keefe, M.D.						22d. ADDRESS Chestertown, Maryland					
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial			23b. DATE THEREOF 4/2/1966			23c. NAME OF CEMETERY OR CREMATORIAL MORGNEC CEM.			23d. LOCATION (City, town or county) (State) NEAR Chestertown, Md		
24. FUNERAL DIRECTOR Kenneth Wally			ADDRESS Chestertown, Md			25a. REC'D BY REGISTRAR APR 4 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

522

52

1967-1968

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

1968-1969

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03873

Reg. Dist. No. 03863

M

1. PLACE OF DEATH a. COUNTY Kent		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		d. STREET ADDRESS 14-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Grover	Middle C.	Last Woodall	4. DATE OF DEATH Month March	Day 14	Year 1966
--	------------------------	---------------------	------------------------	---	------------------	---------------------

5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1882	9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
-----------------------	----------------------------------	--	---	---	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ref. Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming.	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	--	---	---

13. FATHER'S NAME Daniel R. Woodall	14. MOTHER'S MAIDEN NAME Anna E. Hendricks		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO. 216-48-6126	17. INFORMANT Irvin Woodall,	Address Millington, Md. 21651

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arterio sclerotic Cardiovascular Disease DUE TO 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	INTERVAL BETWEEN ONSET AND DEATH 6-8 years
--	--

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatectomy 1/10/1966	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
--	---

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
---	--	--	--	--	--	--

ACTUAL SIGNATURE <i>Robert W. Farr</i>	DATE SIGNED 3-16-66
---	-------------------------------

EXAMINER'S NAME (Type) ROBERT W. FARR	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
---	--

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1966	22c. NAME OF CEMETERY OR CREMATORIUM Crumpton Cemetery.	22d. LOCATION (City, town, or county) Crumpton, Q.A.C.O.; Md.
--	---	---	---

23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Fellow Millington Md</i>	ADDRESS Edward Fellow Millington Md	24a. REC'D BY REGISTRAR DATE MAR 18 1966	24b. REGISTRAR'S SIGNATURE <i>Charles J. Jorgi</i>
--	---	---	---

